IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
WESTERN DIVISION

BRENDA THOMPSON, **Plaintiff,** **vs.** **JO ANNE B. BARNHART[1], COMMISSIONER OF SOCIAL SECURITY,** **Defendant.**	**No. 01CV3009** **ORDER**

Plaintiff, Brenda Thompson, filed a Complaint in this Court on January 26, 2001, seeking review of the Commissioner's decision to deny her claim for Social Security benefits under Title II and Title XVI of the Social Security Act, 42 U.S.C. §§ 401 *et seq*. and 1381 *et seq*. This Court may review a final decision by the Commissioner. 42 U.S.C. §405(g). For the reasons set out herein, the decision of the Commissioner is reversed.

I. BACKGROUND

[1]Jo Anne B. Barnhart became the Acting Commissioner of Social Security on November 14, 2001. Pursuant to Rule 25(d)(1) of the Federal Rules of Civil Procedure, Jo Anne B. Barnhart should be substituted for Larry G. Massanari as the defendant in this suit. No further action need be taken to continue this suit by reason of the last sentence of section 205(g) of the Social Security Act, 42 U.S.C. §405(g).

Plaintiff filed an application for Social Security Disability Benefits on August 2, 1997 claiming to be disabled since December 4, 1996 (Tr. 14). The claim was denied initially and on reconsideration (Tr. 14). On December 15, 1998, following a hearing, an Administrative Law Judge (ALJ) determined that plaintiff was not disabled through the date of the decision. A complaint was filed in this Court on January 26, 2001.

In his decision, following the familiar five step sequential evaluation set out in Polaski v. Heckler, 739 F.2d 1320 (8th Cir. 1984), the ALJ, at the first step, found that plaintiff had not engaged in substantial gainful activity after her alleged onset disability date of December 4, 1996 (Tr. 26). At the second step, the ALJ found that plaintiff's severe impairments were: a history of thoracic outlet syndrome, chronic obstructive pulmonary disease and chest pain, impairments which cause more than minimal restrictions in the ability to perform basic work activity (Tr. 16). At the third step, the ALJ found that plaintiff's impairments do not meet or equal the criteria of a listed impairment listed in Appendix 1 to Subpart P of the Social Security Administration's Regulations No. 4 (Tr. 21). At the fourth and fifth steps, the ALJ found that plaintiff's impairments do not prevent her from performing her past relevant work as a data-entry clerk, a courier, and as an inserting machine operator, as well as other work existing in significant numbers in the national economy (Tr. 25, 27).

II. MEDICAL EVIDENCE

The medical reports that are a part of the record of this case have been carefully reviewed by this court. A summary of those reports, taken from the certified record, follows.

In December 1989, plaintiff had thoracic outlet surgery[2] and in December 1991 was diagnosed with bilateral thoracic outlet syndrome (Tr. 182-87). Functional limitations consistent with work at light level of exertion were identified but no treatment was proposed (Tr. 186). Plaintiff returned to work and was engaged in substantial gainful activity until 1996 (Tr. 106).

In June, 1997, plaintiff underwent cardiac catheterization (Tr. 223-24, 231-32). Her right coronary artery had a 50% proximal lesion and a 98% lesion in the mid-segment (Tr. 223). Angioplasty[3] was successfully performed to both lesions, with a residual stenosis[4] of 20% (Tr. 223).

In July 1996, after a positive treadmill stress test,

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[2]Surgery of the thorax - the upper part of the trunk between the neck and the abdomen. Stedman's Medical Dictionary, 26th Edition.

[3]Procedure involving the introduction of a thin flexible, hollow catheter into an artery in the groin. The catheter is advanced through the blood vessel to the heart. A special balloon tip on the catheter allows the physician to open a diseased (occluded) coronary artery by inflating the balloon and dilating the diseased vessel. Plaintiff's Brief at 5, fn. 5.

[4]Narrowing or stricture of a duct or canal, in this case an artery. Plaintiff's Brief at 5, fn. 6.

plaintiff's family doctor, Anil Shai, D.O., recommended that plaintiff stop smoking and continue exercising. After complaints of blurred and double vision, as well as an aching chest, plaintiff's cardiologist Manmohan L. Kwatra, M.D., found no evidence of myocardial ischemia[5] and a low possibility of recurrent coronary artery stenosis[6] (Tr. 235). Plaintiff underwent a carotid ultrasound which showed a high degree of turbulence in the right subclavian artery[7] (Tr. 285).

In March, 1997, plaintiff, after complaining of constant chest pain, underwent a coronary angiogram[8] which revealed that the right coronary artery showed severe diffuse disease in multiple locations, requiring the insertion of four stents[9] and angioplasty (Tr. 246-47). The left coronary artery appeared to be normal (Tr. 245).

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[5]Inadequate circulation of blood to the myocardium, usually as a result of coronary artery disease. Stedman's Medical Dictionary, 26th Edition.

[6]*Supra*, note 4.

[7]Artery beneath the clavical. Stedman's Medical Dictionary, 26th Edition.

[8]Radiograph obtained by angiography. Stedman's Medical Dictionary, 26th Edition.

[9]Tubes designed to be inserted into a vessel or passageway to keep it open. Stents are inserted into narrowed coronary arteries to help keep them open after balloon angioplasty. The stent then allows the normal flow of blood and oxygen to the heart. Plaintiff's Brief at 7, fn. 10.

In April, 1997, plaintiff was diagnosed with bronchitis with chronic obstructive pulmonary disease (Tr. 260-61). In a letter dated April 23, 1997, Dr. Kwatra indicated that he doubted plaintiff would be able to find a gainful occupation and he recommended disability for an indefinite period of time (Tr. 256).

In September, 1997, plaintiff underwent an esophagogastroduodenoscopy[10] for her complaints of cough, abdominal pain, nausea and episodic vomiting (Tr. 262). That same month the state agency referred her to Dr. Sahai for a consultive examination (Tr. 301-0). Dr. Sahai noted that plaintiff reported smoking one-half package of cigarettes per day for 45 years (Tr. 23, 301). After an examination, Dr. Sahai's impression was that plaintiff suffered from coronary artery disease and hyperlipidemia[11] (Tr. 302).

In October, 1997, after complaining to Dr. Sahai of blurred vision and chest pain, she was admitted and myocardial infarction was ruled out due to the absence of electrocardiogram or enzyme changes (Tr. 306). However, on November 7, 1997, Dr. Kwatra stated that "[b]ased on the medical history of coronary

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[10]Endoscopic examination of the esophagus, stomach and duodenum usually performed using a fiberoptic instrument. Stedman's Medical Dictionary, 26th Edition.

[11]The presence of an abnormally large amount of lipids in the circulating blood. Stedman's Medical Dictionary, 26th Edition.

artery disease[12], repeat coronary angioplasties[13], sever COPD[14], hypertension[15], hyperlipidemia[16], TIA[17], visual disturbance, I recommend total and permanent disability as I strongly feel her disease is progressive in nature" (Tr. 328).

In December 1997, plaintiff was examined by a state agency medical consultant who noted that plaintiff's chest pain was atypical for angina, that pulmonary function studies showed her COPD[18] to be less severe, and that her myocardial perfusion scan was negative (Tr. 342).

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[12]Disease of the blood vessels in the heart. Stedman's Medical Dictionary, 26th Edition.

[13]*Supra*, note 3.

[14]Abbreviation for chronic obstructive pulmonary disease (disease of the lungs). Stedman's Medical Dictionary, 26th Edition.

[15]High blood pressure. Stedman's Medical Dictionary, 26th Edition.

[16]*Supra*, note 11.

[17]Transient ischemic attack (TIA): a neurological event with the signs and symptoms of a stroke, but which go away within a short period of time. Also called a mini-stroke, a TIA is due to a temporary lack of adequate blood and oxygen (ischemia) to the brain. This is often called by the narrowing (or, less often, ulceration) of the carotid arteries (the major arteries in the neck that supply blood to the brain.) Plaintiff's Brief at 7, fn. 8.

[18]*Supra*, note 14.

In February 1998, in a letter addressed to the State Disability Examiner, Dr. Kwatra, stated that plaintiff has recurrent angina pectoris[19] and coronary artery disease. Again, her cardiologist "strongly recommend[ed] patient to be considered for permanent and total disability" (Tr. 343-44). On March 11, 1998, Dr. Kwatra saw the plaintiff again and in a letter to Dr. Sahai, he stated "the patient's symptoms are highly suggestive of severe COPD, hypoxemia, hypercarbia and symptoms, perioral and periorbital numbness, numbness of both upper extremities and chest pain (Tr. 371).

In April, 1998, Dr. H. Richard Hornberger, a state agency medical consultant, reviewed plaintiff's file at the reconsideration level (Tr. 359-68). The consultant concluded that plaintiff could lift and carry no more than 10 pounds, stand and/or walk for two hours in an eight hour workday, and sit for six hours in an eight hour workday (Tr. 360). The consultant found no other limitations upon plaintiff's capacity to perform gainful activity (Tr. 359-68) and further noted that Plaintiff's reports of chest pain were atypical and not supported by objective findings (Tr. 361).

In June, 1998, plaintiff underwent coronary angiography, left heart catheterization, and left ventriculography (Tr. 372-

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[19]Severe constricting pain in the chest, often radiating from the precordium to a shoulder (usually left) and down the arm, due to ischemia of the heart muscle usually caused by coronary disease. Stedman's Medical Dictionary, 26th Edition.

73). Dr. Kwatra concluded that plaintiff had one vessel coronary artery disease and normal left ventricular function (Tr. 373). He concluded that because plaintiff's cardiolite scan was normal, he presumed that the chest pain was non-cardiac or due to vasopastic disease (Tr. 373).

In September 1998, plaintiff complained of feeling that her body was "shutting down" at nighttime. Dr. Sahai impression was bilateral leg pain with episodes of anxiety versus nervousness (Tr. 382). She was put on Depakote which she did not find to be effective so in October 1998, Dr. Sahai started her on Trazodone to help her with her sleeping and depression (Tr. 382).

III. STANDARD OF REVIEW

> The scope of this Court's review is whether the decision of the Secretary in denying disability benefits is supported by substantial evidence on the record as a whole. 42 U.S.C. §405(g). See Lorenzen v. Chater, 71 F.3d 316, 318 (8th Cir. 1995). Substantial evidence is less than a preponderance, but enough so that a reasonable mind might accept it as adequate to support its conclusion. Pickney v. Chater, 71 F.3d 294, 296 (8th Cir. 1996). We must consider both evidence that supports the Secretary's decision and that which detracts from it, but the denial of benefits shall not be overturned merely because substantial evidence exists in the record to support a contrary decision. Johnson v. Chater, 87 F.3d 1015, 1017 (8th Cir. 1996) (citations omitted). When evaluating contradictory evidence, if two inconsistent

> positions are possible and one represents the Secretary's findings, this Court must affirm. Orrick v. Sullivan, 966 F.2d 368, 371 (8th Cir. 1992)(citation omitted).

Fenton v. Apfel, 149 F.3d 907, 910-11 (8th Cir. 1998).

In short, a reviewing court should neither consider a claim de novo, nor abdicate its function to carefully analyze the entire record. Wilcutts v. Apfel, 143 F.3d 1134, 1136-37 (8th Cir. 1998) citing Brinker v. Weinberger, 522 F.2d 13, 16 (8th Cir. 1997).

III. DISCUSSION

A "claimant's residual functional capacity is a medical question." Lauer v. Apfel, 245 F.3d 700 (8th Cir. 2001), quoting Singh v. Apfel, 222 F.3d 448, 451 (8th Cir. 2000). There must be some medical evidence to support the ALJ's determination of the claimant's residual functional capacity and this evidence should address the claimant's ability to function in the workplace. Dykes v. Apfel, 223 F.3d 865, 867 (8th Cir. 2000)(per curiam); Nevland v. Apfel, 204 F.3d 853, 858 (8th Cir. 2000).

The Court is persuaded that there is no medical evidence to support the ALJ's conclusion that plaintiff can return to her past relevant work as a data-entry clerk, a courier, and as an inserting machine operator, as well as do any other work existing in significant numbers in the national economy (Tr. 25, 27). The ALJ concluded that plaintiff had the ability to "stand or walk [for] two hours at a time and [for] six hours in an

eight hour day" (Tr. 24), however, not one doctor opined that plaintiff can stand and walk for two hours at a time for a total of six hours out of an eight hour workday. In fact, three doctors expressed their opinions as to plaintiff's inability to sit and stand for prolonged periods of time during an eight hour work day. In November 1997, Dr. Kwatra, plaintiff's treating cardiologist, found that "she cannot sit, stand or work for more than a couple hours at a time." (Tr. 327). About three months later in February 1998, Dr. Kwatra reported that plaintiff stated she could not "sit or stand for more than 10 minutes." (Tr. 344). Dr. Lawrence Staples, a non-examining state agency medical consultant, reviewed plaintiff's claim and found that she could stand for only two hours in an eight-hour work day. (Tr. 334, 340). Dr. Richard Hornberger, a state agency medical consultant, reviewed plaintiff's record and concluded that she was limited to standing two hours in an eight-hour work day. (Tr. 360). Even the government, at the hearing before this Court, agreed that the ALJ did not do a very thorough job of explaining how he came to the conclusion that plaintiff can "sit two hours at a time and six hours in an eight hour day [and] stand or walk two hours at a time and six hours in an eight hour day". (Tr. 24).

The ALJ stated that "[b]ecause Dr. Kwatra is the claimant's treating cardiologist, his medical opinion is given great weight in this decisionmaking process". (Tr. 23). The ALJ, however, gave very little weight to Dr. Kwatra's opinions of plaintiff's

functional capacity to perform work-related activities, stating that those opinions "were merely quotations of the claimant's own estimation of her physical capacity, and therefore are accorded little weight."(Tr. 23). The Court, however, is persuaded that the ALJ failed to give Dr. Kwatra's opinions the weight they deserve. Dr. Kwatra may have adopted plaintiff's own estimates of what she thought her functional capacity was, but he took her answers to be credible, and he examined her on several occasions regarding her heart problems and made a determination based on all of the medical evidence that she is disabled. Further, the Court is unpersuaded that Dr. Kwatra's opinions should be given little weight simply because he "has not established his credentials as a vocational expert familiar with the availability of occupations or their exertional requirements." (Tr. 18). The fact that he may not be an expert on what jobs people can and cannot do does not take away the fact that he is a cardiologist who has treated the plaintiff for heart problems on various occasions and is no doubt familiar with the plaintiff's exertional limitations due to heart condition.

The ALJ also relied heavily on the vocational expert's testimony, in response to the hypothetical questions posed to him, that plaintiff could return to her past work or to other work in the national economy. The ALJ refused, however, to give any weight to the vocational expert's responses to questions asked on cross-examination which incorporated limitations on

plaintiff's ability to stand, her ability use her arms for reaching, standing and fingering, and her need to take frequent breaks due to her recurrent chest pains. When incorporating these limitations into the hypothetical, the vocational expert testified that plaintiff would not be able to return to her past relevant work or perform any other job.

As the plaintiff's attorney points out in his brief on page 18, "[t]he point of the hypothetical question is to clearly present to the VE [vocational expert] a set of limitations that mirror those of the claimant." Roe v. Chater, 92 F.3d 276, 279 (8th Cir. 1996) (citing Hogg v. Shalala, 45 F.3d 276, 279 (8th Cir. 1995)). This Court is persuaded that hypothetical question number three adopted by the ALJ did not reflect the true limitations the plaintiff has. It was error to adopt hypothetical question number three. The last hypothetical question was much closer to the true situation. (Tr. 70).

Despite the fact that Dr. Kwatra, plaintiff's cardiologist, and Dr. Sahai, plaintiff's family doctor, have diagnosed the plaintiff with coronary artery disease, the government still argues that the she has never been diagnosed with coronary artery disease because "the succession of cardiolite stress tests which consistently fail to support myocardial ischemia." (Tr. 23, 235, 373). The Court finds that it is a play on words that she does not have "heart disease" or "coronary artery disease". The plaintiff has, on several occasions, undergone an angiogram and angioplasty to relieve her clogged arteries;

she has had stent insertions; and she frequently uses nitroglycerin to relieve chest pain. The mere fact that a certain stress test has not positively shown that plaintiff suffers from myocardial ischemia is not enough to persuade the Court that she does not suffer from heart disease.

In reaching his decision, the ALJ also relied heavily on the fact that plaintiff is a smoker who continues to smoke despite recommendations by doctors that she quit. (Tr. 23). The government argues that a finding of disability is not appropriate where the records show that plaintiff's respiratory and other health problems are related to her smoking habit and that she continues to smoke despite being told she should quit. The government cites Roth v. Shalala, 45 F.3d 279, 282 (8th Cir. 1995) to show that it is well established that the unjustified failure to follow a prescribed course of remedial treatment which would enable the claimant to work is grounds for denying benefits in and of itself.

The Court opines that nobody should smoke because it is clearly dangerous to one's health; however, the issue should not be whether plaintiff's smoking habit is clinically remedial, but whether it is reasonably remedial by the plaintiff. *See* Brown v. Sullivan, 902 F.2d 1292, 1296 (8th Cir. 1990)(The court held that the proper question was not whether Brown's obesity is clinically remedial, but whether it is reasonably remedial by Brown. Medical reports showed that Brown had attempted to follow his doctor's instructions to lose weight through diet and

exercise, however, his failure to do so was not willful.) Here, the plaintiff had, at one point, been smoking up to four packs of cigarettes a day. (Tr. 19). She has, however, attempted to quit several times. She has tried quitting by using the nicotine patch, by taking the prescription medication Zyban, and through hypnosis. None of these methods were enough to get her to kick her addiction, however, she has been able to cut down to a half a pack a day (roughly ten cigarettes). Ten cigarettes is still a lot, but it is a significant improvement from four packs a day (roughly eighty cigarettes). The fact that she has not been able to quit smoking, shows she has a strong addiction to nicotine that she has not been able to beat, but it hardly shows she is a liar. This Court is not persuaded that her failure to quit automatically precludes her from benefits.

IV. CONCLUSION

This Court holds that the ALJ's decision is not supported by substantial evidence in the record as a whole. The medical evidence establishes that plaintiff does not have the residual functional capacity to perform her past relevant work or any other work in the national economy. A reversal with an award of benefits as of **November 7, 1997** is the appropriate remedy. This date is appropriate because it is the first time Dr. Kwatra, plaintiff's cardiologist, flatly recommended total and *permanent* disability because he felt her disease was "progressive in nature." (Tr. 328).

This cause is reversed and remanded to the Commissioner for computation and payment of benefits. The judgment to be entered

will trigger the running of the time in which to file an application for attorney's fees under 28 U.S.C. §2412(d)(1)(B)(Equal Access to Justice Act). See Shalala v. Schaefer, 509 U.S. 292 (1993) and LR 54.2(b).

IT IS SO ORDERED.

DATED this ___ day of March, 2002.

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Donald E. O'Brien, Senior Judge
United States District Court
Northern District of Iowa